NEW PATIENT MEDICAL HISTORY INFORMATION

Name:	Date:

Medical History (4)

If you are being referred to this office by another doctor, please list the name of the referring physician and his or her address:

Doctor Use Only
HPI (4 Elements Needed)

Location	Duration
Quality	Timing
Severity	Context
Mod factors	Signs/Symp

Review outside records

If you are a self-referred patient, please list the doctors to whom you would like your work-up sent:

Major reason for coming to the doctor:

Has a diagnosis for this problem been established? ☐ Yes ☐ No
If yes, what is the diagnosis and how was it established?

How does this problem affect how you feel day to day?

How long have you had this problem?

What laboratory testing, including x-rays, have you had?

What treatment have you had for this problem?

Which physicians have treated you in the past for this problem?

Medications

List all medications that you are taking (prescription or over the counter):

Medication	Dose	Frequency

List medications to which you are allergic:

Past Medical History
List any surgeries that you have had:
List serious illnesses that you have had:
List serious injuries:

Social History [1]	
Marital status: ☐married ☐single ☐widowed ☐divorced	Number of Children:
Occupation:	Religious preference:
Do you drink? ☐Yes ☐No If yes, do you have more than 14 drinks per week? ☐Yes ☐No	
Have you ever smoked? ☐Yes ☐No How many years?_____ Do you smoke now? ☐Yes ☐No How many packs a day?_____	

Family History [1]	
List family members with any of the following:	
Diabetes: Type 1_____ Type 2_____	Cancer:
Stroke:	Thyroid disease:
Coronary Artery disease (heart attacks, bypass surgery, angioplasty/stenting):	

Health Maintenance

Are you up to date on the following:

☐Yes ☐No Pap smear (women only)
☐Yes ☐No Mammogram (women only, yearly after age 50)
☐Yes ☐No Colonoscopy (colon cancer, every 5-10 years after age 50)
☐Yes ☐No Hemocoult: Test for blood in stool (colon cancer, yearly after age 50)
☐Yes ☐No Prostate Cancer blood test (PSA, men only)
☐Yes ☐No Bone density study (women and men) Year?_____

Have you had the pneumonia vaccine (Pneumovac)? ☐Yes ☐No

Date of your last dilated eye exam:

Please check (☑) any problems you may be having:

General:
☐ Fever
☐ Chills
☐ Weight Loss
☐ Weight Gain
☐ Fatigue
☐ Headache

Eyes:
☐ Blurred Vision
☐ Floaters
☐ Infection
☐ Redness
☐ Pain in Eyes

Ears/Nose/Throat:
☐ Earache
☐ Hearing Loss
☐ Sinus Infection
☐ Sores in Mouth
☐ Sore Throat

Heart:
☐ Chest Pain
☐ Shortness of Breath
☐ Heart Racing
☐ Heart Pounding
☐ Ankle Swelling

Lungs:
☐ Asthma
☐ Wheezing
☐ Cough
☐ Stop Breathing at Night (sleep apnea)
☐ Use CPAP machine

Bowels:
☐ Heartburn
☐ Acid Indigestion
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Blood in Stools
☐ Trouble swallowing
☐ Black stools

Kidneys:
☐ Burning with Urination
☐ Loss of Urine
☐ Blood in Urine
☐ Difficulty with Urine Flow

Musculoskeletal:
☐ Joint Pain
☐ Muscle Pain
☐ Back Pain
☐ Thin Bones
☐ Bone Fractures

Neurologic:
☐ Numbness/Tingling
o Hands
o Feet
☐ Dizziness
☐ Balance Problems
☐ Muscle Weakness

Psychiatric:
☐ Anxiety
☐ Depression

Hormonal:
☐ Thyroid Disease
☐ Menstrual Problems
☐ Erection Problems
☐ Excess Facial Hair
☐ Adrenal Disease
☐ Pituitary disease

Skin/Breast:
☐ Rash
☐ Moles
☐ Breast Mass
☐ Breast Soreness

Blood/Lymph:
☐ Swollen Lymph Nodes
☐ Easy Bruising
☐ Bleeding Gums

Allergies:
☐ Hay Fever
☐ Hives
☐ New allergies to medication

Do you have any skin lesions that you are worried may be cancerous or pre-cancerous? ☐Yes ☐No

Other problems to discuss with the doctor:
1. _____
2. _____
3. _____